

AUTHORIZATION

For the Use and Disclosure of Protected Health Information

Mail To: Privacy Officer, Colorado Department of Health Care Policy and Financing
1570 Grant Street, Denver, CO 80203

*** Please include copy of your Medicaid ID card and Driver's License, or equivalent ***

The Health Insurance Portability and Accountability Act of 1996 states that we cannot share your protected health information without your permission, except in certain situations. For example, your protected health information can be shared without your permission if it is used to facilitate your health care treatment, payment, or for health plan operations. If you sign this form, you are giving us permission to share the protected health information you indicate below. This does not protect the information from being shared with more people once it leaves our office.

This authorization will only last until the date you specify, and must expire on a specific date or upon the occurrence of a specific event.

If you decide later that you do not want us to share your protected health information any more, you may cancel your authorization at any time by signing the REVOCATION SECTION at the end of this form and returning it to Colorado Department of Health Care Policy and Financing Privacy Officer indicated above. Any revocation can only apply to future disclosures or actions regarding your protected health information and cannot cancel actions taken or disclosures made while the authorization was in effect. See the Department's Privacy Policies and Procedures on *Use and Disclosure of Protected Health Information – Authorization Required*, pursuant to 45 C.F.R. 164.508.

Date: _____

Person or group authorized to receive and use my protected health information:

I, _____ (print your name) **authorize the Colorado Department of Health Care Policy and Financing to share the protected health information checked below with the person or group listed above:**

☐ Information related to eligibility for benefits for the following time period (specify dates):

From: _____ To: _____

☐ Information including claims, reports, and other documents related to claims for benefits from a certain time period (specify dates):

From _____ To _____

☐ Information relating to payment or lack of payment of benefits for services rendered on a specific date:

Date: _____ Name of health care provider: _____

☐ Other (specify): _____

Purpose of request for information: (If you prefer not to state a purpose, please state "At the request of the individual")

Expiration of authorization: (You must specify a date or event, i.e., at the end of litigation)

Date / event of expiration: _____

I understand the Colorado Department of Health Care Policy and Financing can not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.

State ID number: _____ Signature: _____

Date of birth: _____ Social Security # : _____

Name of Designated Personal Representative: _____

*** Legal documentation must be included to show authority to receive information ***

Signature of Designated Personal Representative: _____

Relationship of Designated Personal Representative: _____

I am entitled to receive a copy of this Authorization. Please mail to the following address:

Street address: _____

City, State, Zip: _____

REVOCATION SECTION

I understand that I have the right to revoke this authorization at any time by notifying the Department's Privacy Officer at the above address. I understand that the revocation is only effective after it is received and logged by the Department's Privacy Officer. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

I no longer want my protected health information used or disclosed to the person listed above.

Signature: _____ Date: _____